UnumProvident

LONG TERM CARE

Underwritten by:
Unum Life Insurance Company of America
LTC Department – A204
2211 Congress Street, Portland, Maine 04122

NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM

Long Term Care Insurance

Benefit Election Form

Policy #510487

Your Name: (Last Name, First, Middle Initial)	Social Security Number __ __ __ - __ __ - __ __ __ __	Date of Birth (MM/DD/YYYY) __ __/__ __/__ __ __ __
Street Address	Gender ☐ Male ☐ Female	Date of Hire (MM/DD/YYYY) __ __/__ __/__ __ __ __
City, State, Zip Code	Home Telephone # ( )	Work Telephone # ( )

Complete the following only if applicant is not the employee

Employee's Name	Employee Social Security No. __ __ __ - __ __ - __ __ __ __	Employee Date of Birth __ __/__ __/__ __ __ __	Employee Date of Hire __ __/__ __/__ __ __ __

Applicant Is:

☐ Employee	☐ Retiree
☐ Employee's Spouse	☐ Retiree's Spouse

You may choose any of the plans listed below. The Long Term Care Application (medical questionnaire) and Benefit Election form must be completed and you must be approved for coverage in order to enroll in the Long Term Care plan.

Plans *(Check one)*

☐ Plan 1A
- Nursing Home Facility / $3,000 Monthly Benefit
- Professional Home Care

☐ Plan 2A
- Nursing Home Facility / $3,000 Monthly Benefit
- Professional Home Care
- Total Home Care

☐ Plan 3A
- Nursing Home Facility / $3,000 Monthly Benefit
- Professional Home Care
- Simple Inflation

☐ Plan 4A
- Nursing Home Facility / $3,000 Monthly Benefit
- Professional Home Care
- Total Home Care
- Simple Inflation

☐ Plan 1B
- Nursing Home Facility / $3,000 Monthly Benefit
- Paid Up Benefit
- Professional Home Care

☐ Plan 2B
- Nursing Home Facility / $3,000 Monthly Benefit
- Paid Up Benefit
- Professional Home Care
- Total Home Care

☐ Plan 3B
- Nursing Home Facility / $3,000 Monthly Benefit
- Paid Up Benefit
- Professional Home Care
- Simple Inflation

☐ Plan 4B
- Nursing Home Facility / $3,000 Monthly Benefit
- Paid Up Benefit
- Professional Home Care
- Total Home Care
- Simple Inflation

Facility Benefit Duration *(Duration of benefits may vary depending on where benefits are received.)*

(Check one)	☐ 3 Years	☐ 5 Years

If you are an Active Employee's Spouse your premium will be paid through the employee's payroll deduction, please sign below. Employee must sign below to authorize the employer to make the payroll deduction.
Retirees will be billed directly by the insurance company.
Retirees, how would you like to be billed? ☐ Quarterly ☐ Semi-Annually ☐ Annually

Caution: if your answers on this Enrollment Form are incorrect or untrue, we may have the right to deny benefits or rescind your insurance.

By signing below, you signify that you have read and understand that loss of Activities of Daily Living (ADL) or Severe Cognitive Impairment must occur after your effective date of coverage under this Long Term Care plan in order to be covered, and that certain limitations and exclusions apply to your coverage. This information is contained in your kit.

Your Premium: $_____ ***(Transfer the premium amount from the rate sheet.)***

_____	__ __/__ __/__ __ __ __	_____	__ __/__ __/__ __ __ __
Applicant's Signature	*Date*	*Employee's Signature*	*Date*

Employees and spouses, sign and submit this form to your employer. Other applicants, sign and mail to UnumProvident (address at top of page). You may want to make a copy for your records.

If you have questions about Long Term Care coverage, please call UnumProvident's toll-free number: 1-800-227-4165.